

Case Number:	CM14-0151604		
Date Assigned:	09/19/2014	Date of Injury:	05/30/2013
Decision Date:	11/04/2014	UR Denial Date:	08/21/2014
Priority:	Standard	Application Received:	09/17/2014

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in Indiana. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 46-year-old female with a diagnosis of discogenic low back pain, lumbar spine musculoligamentous injury with discopathy, and L5-S1 herniated nucleus pulposus with stenosis. The worker is a restaurant worker with a date of injury of 5/30/13. The worker complained of lower back pain with pain radiating down the back of both legs, right greater than left, with symptoms exacerbated by prolonged sitting, walking standing, bending, twisting, and lifting activities. The worker was noted to have a positive seated straight-leg raising test bilaterally. An MRI of the lumbar spine performed on 9/11/13 revealed a broad-based disc bulge at L5-S1, L4-5, L3-4 and L2-3 with no canal stenosis except at the L5-S1 level with associated severe bilateral neural foraminal narrowing. The disc at L5-S1 was also noted to indent the ventral aspect of the thecal sac and may contact descending nerve roots. As of 12/26/13, the worker complained of frequent low back pain despite conservative treatment with PT and medications. A chiropractic note dated 1/15/14 notes that the worker is slowly improving with some low back pain, right > left with limitation of motion of the lumbar spine in all planes. The treating physician is requesting retrospective approval for 24 chiropractic visit for dates of service 11/13/13 - 3/21/14 for the lumbar spine.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Retrospective 24 chiropractic visits for dates of service 11/13/13 to 3/21/14 for the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-299.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58 - 60. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: ACOEM V.3, Low Back > Treatments > Allied Health Therapies

Decision rationale: According to the CA MTUS Chronic Pain Medical Treatment Guidelines, A Delphi consensus study based on this meta-analysis has made some recommendations regarding chiropractic treatment frequency and duration for low back conditions. They recommend an initial trial of 6-12 visits over a 2-4 week period, and, at the midway point as well as at the end of the trial, there should be a formal assessment whether the treatment is continuing to produce satisfactory clinical gains. If the criteria to support continuing chiropractic care (substantive, measurable functional gains with remaining functional deficits) have been achieved, a follow-up course of treatment may be indicated consisting of another 4-12 visits over a 2-4 week period. According to the study, "One of the goals of any treatment plan should be to reduce the frequency of treatments to the point where maximum therapeutic benefit continues to be achieved while encouraging more active self-therapy, such as independent strengthening and range of motion exercises, and rehabilitative exercises. Patients also need to be encouraged to return to usual activity levels despite residual pain, as well as to avoid catastrophizing and overdependence on physicians, including doctors of chiropractic."The ACOEM V.3 Guidelines state: If an acute LBP patient is positive for the Clinical Prediction Rule (see Manipulation and Mobilization section), then immediate treatment with manipulation is one treatment strategy. However, there is no quality study that demonstrates the superiority of manipulation for Clinical Prediction Rule-positive patients compared with the other treatment strategies (e.g., NSAIDs, progressive walking program, directional stretching, and heat) contained in this chapter. If other interventions that have evidence of efficacy have failed, it may be acceptable to use chiropractic care as a secondary treatment option adjunct to a program of evidence-based functional restoration if tied to signs of objective functional recovery within 2 weeks that is faster than the progress expected with the rate of usual spontaneous recovery. In this worker's case, the chiropractic treatments were not instituted until 6 months after the acute injury, there is no medical documentation that other treatment strategies have failed, and the requested 24 treatments over 4 month period of time exceed the CA MTUS guideline recommendations for a maximum of 24 sessions over an 8 week maximum period of time. Therefore, neither the CA MTUS guidelines or ACOEM V.3 Guidelines for chiropractic treatments have been met and the requested chiropractic visits are not medically necessary.